Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: WALLS REGIONAL HOSPITAL PO BOX 203500 AUSTIN TX 78720-3500	MFDR Tracking #:	M4-09-1377-01
Respondent Name and Box #: Liberty Insurance Corp. Box #: 28		

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "We have appealed this bill twice to Liberty Mutual. They continue to deny our appeals and our requests to process bills according to DWC Rule 134.401. Please review our request for MDR. Additional payment due is $8470.87"

Principle Documentation:

1. DWC 60 Package
2. Total Amount Sought - $8,470.87
3. Hospital Bill
4. EOB
5. Medical Records

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "These services have been reimbursed based upon review and appropriate application of the three-tiered service-related standard per diem amount under 28 TAC Section 134.401(c). Any additional reimbursements described in 28 TAC Section 134.401(c)(4) have been made in accordance with that rule. All charges have been subject to audit as described in 28 TAC Section 133.301(a) and 134.401(b)(2)(C). Because the three-tiered service-related per diem amounts already incorporate complexity and intensity factors, all admission types requiring 'fair and reasonable' reimbursement are reimbursed using the appropriate standard per diem amount which meets or exceeds the appropriate reimbursement in relation to the nature, complexity and intensity of the documented admission."… "there is no evidence that there is anything particularly 'unusually costly or extensive' about this hospital admission. The case falls into DRG 445, which by definition is a DRG that does not reflect any complications or comorbidities. The relative weight of this DRG is 0.52. The length of stay of this particular admission at **one day** is below the average mean length of stay of 2.8 days as documented within the DRG Guide, further reflective of the fact that this was a straightforward, uncomplicated hospitalization. The 2007 National Average payment for this DRG is $2,583.39. Review of the operative reports and coding indicate that no specific procedures were performed which are not typical for this DRG."… "Payment of this hospitalization at the standard surgical per diem established by the Texas Fee Schedule, supplemented by a cost-plus formula for all documented implantables, constitutes a fair and reasonable reimbursement for this bill. Therefore, no additional reimbursement is allowed at this time."

Principle Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
11/10/2007	42 / Z710, 150 / Z652	Inpatient Trauma Surgery	$8,470.87	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006 set out the reimbursement guidelines.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
   - 42 / Z710 – "The charges for this procedure exceeds the fee schedule allowance."
   - 150 / Z652 – "Recommendation of payment has been based on a procedure code which best describes services rendered."
2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 881.10. The Division therefore determines that this inpatient admission is a trauma admission and shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. Division rule at 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective May 25, 2008, 33 TexReg 3954, and applicable to disputes filed on or after May 25, 2008, requires that the request shall include "a position statement of the disputed issue(s) that shall include"… "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues"… This request for medical fee dispute resolution was received by the Division on October 17, 2008. Review of the requestor's position statement finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed by the Division sufficient to meet the requirements of 28 TAC §133.307(c)(2)(F)(iii).
6. Division Rule at 28 TAC §133.307(c)(2)(G), effective May 25, 2008, 33 TexReg 3954, and applicable to disputes filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable". The requestor's position statement does not articulate a methodology under which fair and reasonable reimbursement should be calculated; however, the requestor's rationale for increased reimbursement from the *Table of Disputed Services* states "Per Rule 134.401 certain ICD-9 codes billed as primary dx are excluded form inpt per diem methodology + the entire bill should be paid @ F+R for trauma care the F+R geographic reimbursement is 75% of billed charges." [sic] Review of the requestor's rationale for increased reimbursement finds that the requestor did not discuss or explain how it determined that 75% of the billed charges would result in a fair and reasonable reimbursement. Nor did the requestor submit evidence, such as redacted EOBs showing typical carrier payments, nationally recognized published studies, Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments, to support the proposed methodology. The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, ensure that similar procedures provided in similar circumstances receive similar reimbursement, or otherwise satisfy the statutory requirements and Division rules. Review of the submitted documentation finds that he requestor has not met the requirements of 28 TAC §133.307(c)(2)(G).
7. Additionally, the Division has determined that a methodology based on a percentage of billed charges does not, in itself, produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 *Texas Register* 6276 (July 4, 1997) that "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission

resources." Review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment in the amount of 75% of the billed charges would be a fair and reasonable rate of reimbursement for the services in dispute. Therefore, reimbursement in the amount of 75% of the provider's billed charges cannot be recommended. Thorough review of the documentation submitted by the requestor finds that the requestor has not discussed, demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

8. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative code §133.307(c)(2)(F)(iii) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to meet its burden of proof to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code § 413.011(a-d), § 413.031 and § 413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date

VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.